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COLLABORATIVE

A SPECIALTY HOSPITAL SYSTEM
FOR THE TREATMENT OF
EATING DISORDERS

NAADAC Northwest Regional Conference 2019

Eating Disorders and Substance Use Disorders: Assessment, Conceptualization, and Treatment

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Introduction and Disclosures

Alyssa Kalata is an employee of Veritas Collaborative.

As a for-profit hospital, Veritas Collaborative is not considered a commercial interest by the ACCME.

She has no financial relationships to disclose.

Presentation Overview

- Epidemiology
- Assessment
- Treatment Modalities
- Case Conceptualization
- Interventions
  - Psychotherapeutic
  - Dietetic
  - Medical

Epidemiology – Eating Disorders (EDs)

- At least **30 million** people in the United States meet clinical criteria for an eating disorder diagnosis at some point in their lifetime.
- Prevalence rates by diagnosis:
  - Anorexia Nervosa: 0.6% average lifetime prevalence in the United States
  - Bulimia Nervosa: 1% average lifetime prevalence in the United States
  - Binge Eating Disorder: 2.8% average lifetime prevalence in the United States
  - ARFID: prevalence rates still being studied, may affect up to 5% of children
- Prevalence rates by population:
  - Most common among cis-females (85-90%), however becoming increasingly prevalent among cis-males as well; transgender individuals are particularly vulnerable
  - Bulimia Nervosa and Binge Eating Disorder are more prevalent among Latino and African-American populations than non-Latino Caucasian populations
  - Inpatient admissions for eating disorders treatment for individuals over the age of 40 is increasing

Epidemiology – Substance Use Disorders (SUDs)

- Prevalence by diagnosis:
  - Alcohol Use Disorder (AUDs): 29.1% lifetime prevalence
  - Nicotine Use Disorder (NUDs): 27.9% lifetime prevalence
  - Drug Use Disorders (DUDs): 9.9% lifetime prevalence
- More prevalent among:
  - Men
  - Caucasian and Native American populations
  - Members of the LGBT community
  - Younger individuals
  - Previously or never married people
  - Individuals with lower education and income
- Helpful resource: Substance Abuse Treatment: Addressing the Specific Needs of Women (TIP 51)

Epidemiology – Comorbid EDs and SUDs

- Eating Disorders and Substance Use Disorders Overall
  - 50% of patients with an ED will abuse a substance
  - 35% of individuals who abuse substances have an ED
- Eating Disorders and Substance Use Disorders By Eating Disorders Subtype
  - BN typically has the highest association with substance use, followed by BED
  - Substance use in AN may be more common than originally thought
    - Likely accounted for by patients diagnosed with AN-B/P
    - Patients diagnosed with AN-R may actually have lower rates of substance use than the general population
- Eating Disorders and Substance Use Disorders by Substance Use Disorder Subtype
  - Alcohol Use Disorders are most common among individuals diagnosed with BN, BED, or AN-B/P
  - Use of caffeine and tobacco across eating disorder subtypes reported across studies has been inconsistent, although may be slightly higher in individuals diagnosed with AN; amphetamine use is higher in patients with AN
  - Use of illicit substances is higher in individuals with EDs, with the exception of individuals who meet criteria for AN-R

Epidemiology – Key Take-Home Points

- EDs and SUDs co-occur on a regular basis
  - Purging behavior and correlation with substance use
- Stereotypes about populations of individuals struggling with EDs and SUDs
- Correlations between class of substance used and eating disorder diagnosis

Assessment of EDs and SUDs

- The Importance of Multidisciplinary Assessment
- Screening and Quantitative Assessment
  - Eating Disorders: EDE-Q, DSED, BUILT-R, EAT, EDI-2, EDQ, QEWP
  - Substance Use Disorders: SCOFF, CAGE, TWEAK, MAST, ADS, DAST, DSQ
    - Assessment of Withdrawal: CIWA-Ar, COWS
  - Labs: Urinalysis, Blood Chemistry, EKG, Stool Samples, Imaging
    - Practice Guideline for the Treatment of Patients With Eating Disorders (Third Edition): https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
- Qualitative Assessment
  - Assessment as a method to begin to explore function of ED and SUD
  - Provider qualities when conducting qualitative assessment
  - Obtain collateral information when feasible

Determining Appropriate Levels of Care – APA Guidelines – Level of Care Guidelines

- Practice Guideline for the Treatment of Patients With Eating Disorders (Third Edition):
  - Assessment of the following domains:
    - Medical status
    - Suicidality
    - Weight as percentage of healthy body weight
    - Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts
    - Co-occurring disorders (substance use, depression, anxiety)
    - Structure needed for eating/gaining weight
    - Ability to control compulsive exercise
    - Purging behavior (laxatives and diuretics)
    - Environmental stress
    - Geographic availability of treatment program

Determining Appropriate Levels of Care – APA Guidelines – Current Levels of Care

Medical Acute Crisis

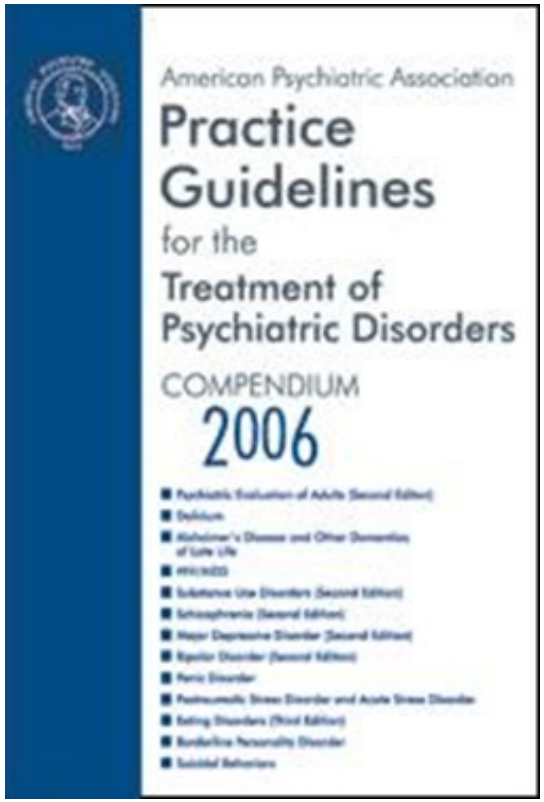
Inpatient (IP)

Acute Residential (RES)

Partial Hospitalization (PHP)

Intensive Outpatient (IOP)

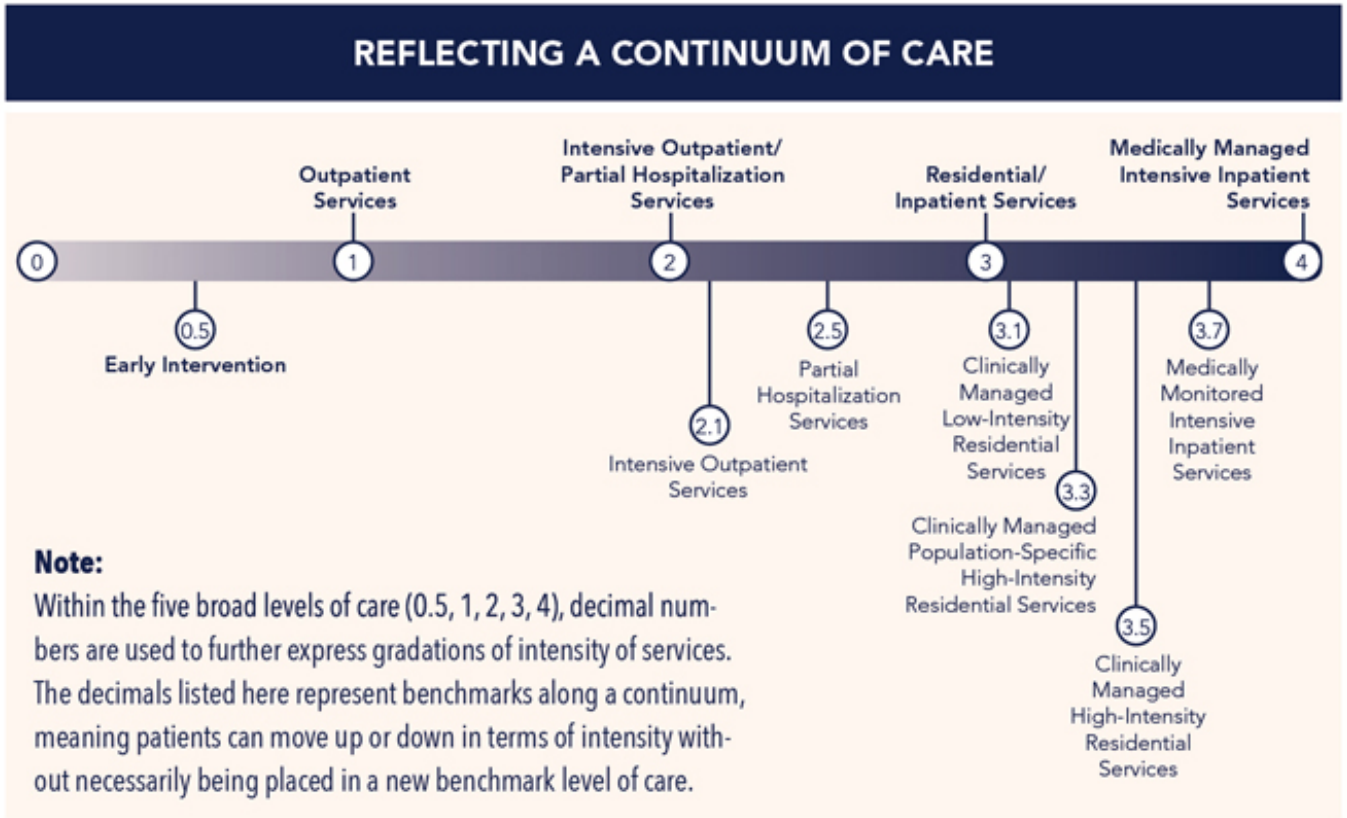
Outpatient (OP)



Revision- Guidelines Watch August 2012

Determining Appropriate Levels of Care – ASAM Criteria – The Six Dimensions of Multidimensional Assessment

Determining Appropriate Levels of Care – ASAM Criteria – Continuum of Care



Determining Appropriate Levels of Care - Considerations With ED and SUD Comorbidity

- Eating Disorders and Substance Use Disorders should be:
  - Addressed simultaneously
  - Utilizing a multidisciplinary approach
  - At the appropriate Level of Care for an appropriate duration of time

Let's Practice!

- Think of a patient you currently treat or have treated who struggles with an eating disorder, and use the APA Guidelines to make a determination about the appropriate Level of Care
  - If you have not treated a patient with an eating disorder previously, a vignette has been provided

Common Therapeutic Modalities Used in the Treatment of Comorbid EDs and SUDs

- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing (MI) / Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Mindfulness-Action Based Cognitive Behavioral Therapy (MACBT)
- Adjunct Treatments:
  - Mutual Support Programs (AA/NA/CA and SMART Recovery) for Substance Use Disorders
  - Family-Based Therapy for Eating Disorders

Multidisciplinary Case Conceptualization

- The importance of understanding the function of behaviors and the possibility of behaviors with different topographies serving comparable functions
  - Weight Loss:
    - ED Behaviors: Restricting, compulsive exercise
    - Substances: Caffeine, tobacco, insulin, thyroid medications, stimulants, laxatives, diuretics
  - Decreasing Negative Affect:
    - ED Behaviors: Restricting, bingeing, purging, compulsive exercise
    - Substances: Alcohol, psychoactive substances
  - Increasing Positive Affect:
    - ED Behaviors: Restricting, bingeing, purging
    - Substances: Alcohol, psychoactive substances
- Conceptualization of disorders as disorders of undercontrol vs. disorders of overcontrol

Let's Practice!

- Using the previous slide as a guide, sketch out a brief case conceptualization of a patient with whom you currently work or with whom you have worked who struggles with an eating disorder and/or substance use disorder
  - If you have not treated a patient with an eating disorder or substance use disorder previously, use the vignette provided for practice

Psychotherapeutic Interventions for Comorbid EDs and SUDs

- Building a collaborative therapeutic relationship
- Psychoeducation
- Enhancing motivation for treatment and recovery
- ABC Model / ARC Model / Chain Analysis / Behavior Analysis
- Building of skills and coping mechanisms
- Cognitive challenging of attitudes and beliefs
- Relapse prevention

Building a Collaborative Therapeutic Relationship

- Psychotherapy as a "social healing practice"
  - Key elements of the therapeutic relationship that impact outcomes in psychotherapy: Goal consensus/collaboration, empathy, alliance, positive regard/affirmation, congruence/genuineness, cultural adaptation
- EDs and the therapeutic relationship
  - Recommendations regarding therapeutic stance from RO DBT: Relaxed and playful professional style, responsive and flexible, treating patient as a person of equal status, willingness to demonstrate vulnerability, approach of open curiosity and willingness, actively addresses and repairs alliance ruptures
- SUDs and the therapeutic relationship
  - "Butterfly" patients

Psychoeducation

- Psychoeducation about physical and psychosocial effects of eating disorders and substance use disorders, and the factors that contribute to the development of these disorders
- Addressing misconceptions that perpetuate guilt and shame (e.g. substance use is a moral failing), lead to maintenance of the disorder (e.g. purging is an effective form of weight control), and/or prevent individuals from seeking treatment (e.g. medication assisted treatment is just swapping one addition with another)
- Orientation to the treatment approach being used

Enhancing Motivation for Treatment and Recovery – Values-Based Work

- Showing intense interest in our patient as a person, and helping them to define and build their own "life worth living"
- From an eating disorder standpoint, helps to address the overvaluation of shape and weight (when pertinent) through increasing the number and significance of other domains for self-evaluation
- From a substance use disorder standpoint, can address key triggers for substance use (e.g. boredom, loneliness)
- Can also help to set the stage for developing discrepancy (part of Motivational Interviewing)
- Exploring values across life domains:
  - Writing exercises
  - Values card sort
  - Assessments

Enhancing Motivation for Treatment and Recovery – Motivational Interviewing

- Principles:
  - Express empathy through reflective listening
  - Develop discrepancy between the client's goals or values and their current behavior
  - Avoid argument and direct confrontation
  - Adjust to client resistance rather than opposing it directly
  - Support self-efficacy and optimism
- Examples of matching your intervention to the patient's stage of change:
  - Procontemplation: Exploring events that led your patient to seek treatment
  - Contemplation: Emphasize client control, acknowledge ambivalence, use pros and cons
  - Preparation: Offering a menu of change options
  - Action: Developing a coping plan
- To learn more:
  - https://store.samhsa.gov/shin/content//SMA13-4212/SMA13-4212.pdf

Enhancing Motivation for Treatment and Recovery – Commitment Strategies

- Evaluating the Pros and Cons
- Playing the Devil's Advocate
- Foot-in-the-Door/Door-in-the-Face Techniques
- Connecting Present Commitments to Prior Commitments
- Highlighting the Freedom to Choose and the Absence of Alternatives
- Using Principles of Shaping
- Cheerleading
- Agreeing on Homework

ABC Model / ARC Model / Chain Analysis / Behavior Analysis

- ABC Model = Antecedents, Behavior, Consequences
- ARC Model = Antecedents, Response (including thoughts, feelings, and behaviors), Consequences
- Chain Analysis = vulnerability factors in play prior to the target behavior and emotions, behaviors, bodily sensations, thoughts, and environmental events that occur before and after the target behavior
- Behavior Analysis = compilation of insights gained about patterns based on multiple chain analyses

Building of Skills and Coping Mechanisms

- Dialectical Behavior Therapy skills designed to treat both EDs and SUDs:
  - Urge Surfing
  - Alternate Rebellion
  - Burning Bridges
  - Dialectical Abstinence
- Skills from other therapeutic modalities (e.g. CBT, ACT)

Cognitive Challenging of Attitudes and Beliefs

- Examples of cognitions:
  - ED cognitions: "I'm not hungry so I don't need to eat my morning snack," "I need to restrict a little bit so that if I eat more on a day I won't go over my maintain weight," "I'm not sick enough to deserve treatment"
  - SUD cognitions: "Smoking weed isn't a problem, it's opiates that ruined everything for me," "It's been a crappy day, I deserve just one drink," "I need to keep wine glasses in the house for when we have company"
  - Cognitions that increase unpleasant emotions: "Things will never get better," "I'm worthless"
- Examples of cognitive approaches:
  - Learning to observe and describe thoughts as thoughts rather than facts
  - Exploring the thought (e.g. Does this thought get me in trouble and if so, how? Does the data I have available support this thought and if not, why?)
  - Identifying the cognitive error (e.g. black-and-white thinking, emotional reasoning)
  - Generating statements that are aligned with facts, goals, and values

Relapse Prevention

- Common Topics
  - Cultivating and Sustaining Motivation (e.g. Pros and Cons, Connecting With Values)
  - Maintaining Positive Changes
  - Building and Maintaining Structure
  - Addressing Current and Potential Challenges, Including Triggers and High Risk Situations
  - Identifying Warning Signs
  - Challenging Disordered Thinking
  - Identifying and/or Creating a Support Network
  - Addressing Lapses and Relapses
- Relapse Prevention Plans
  - Living document
  - Shared with multidisciplinary team and identified supports

Let's Practice!

- Think of a patient with whom you currently work or with whom you have worked who struggles with an eating disorder and/or substance use disorder. If you have not treated a patient with an eating disorder or substance use disorder previously, use the vignette provided for practice.
  - How could the aforementioned interventions fit in to a treatment plan?
  - How would you sequence these interventions?
  - What feels like it is missing from your treatment plan?

Dietetic Interventions for Comorbid EDs and SUDs

- Dietetic education
- Establishing "regular eating"
- Addressing and challenging dietary rules
- Developing skills
- Specific considerations when working with comorbid SUDs
  - Changes in craving
  - Interplay between substance use and eating disorder behaviors
  - Specific body image fears

Medical Interventions for Comorbid EDs and SUDs

- Caveats and considerations
  - Familiarize yourself with the medical complications associated with specific eating disorders and specific classes of substances
- Recommended medical interventions:
  - Labs: Urinalysis, Blood Chemistry, EKG, Stool Samples, Imaging
    - Used to inform medical interventions that may be needed
- Potential contraindications:
  - Depend on substances being used and ongoing risk assessment and cost/benefit analysis
  - Contraindication for bupropion due to increased seizure risk
  - A word on cannabis
- Examples of situations of heightened risk:
  - Patient who engages in purging behavior and who has an alcohol use disorder and/or benzodiazepine use disorder
  - Patient who is at risk for cardiovascular complications due to their eating disorder (e.g. arrhythmia due to electrolyte imbalance) and who has an opioid use disorder

Summing It All Up

- Eating Disorders and Substance Use Disorders commonly co-occur and these patients are at increased medical and psychiatric risk – thorough assessment is key
- Multidisciplinary treatment at the right level of care for the appropriate duration of time that targets both disorders concurrently is critical
- Literature on best practices in the treatment of comorbid Eating Disorders and Substance Use Disorders is limited, although there are promising directions

Translating Training in to Practice

- What is one topic that was discussed today that you will plan to learn more about?
- What is one assessment or treatment strategy that was discussed today that you will make intentional efforts to incorporate in to your practice?
  - How will you go about doing this?
  - What barriers do you anticipate encountering? How will you address these barriers?
  - When will you evaluate how things are going with the assessment or treatment strategy you have chosen to use?

Questions?

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